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VETERANS HEALTH ADMINISTRATION

Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance

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Executive Summary

Following the VA MISSION Act of 2018, VA launched its Veterans Community Care Program, which consolidated several community care initiatives into one permanent program.[1] This program allows the Veterans Health Administration (VHA) to purchase care for veterans through Community Care Network (CCN) contracts or veterans care agreements.[2] The CCN groups VA medical facilities into five regions managed by two third-party administrators (TPAs)—Optum for regions 1, 2, and 3, and TriWest for regions 4 and 5.[3] The CCN is designed to improve care coordination and make it easier for community care providers and VA staff to serve veterans by expanding healthcare services, improving customer service, enhancing how health information is exchanged, and refining the referral and scheduling processes.

The Office of Integrated Veteran Care (IVC) is responsible for overseeing community care access, including execution of the CCN contracts, to ensure VA medical facilities have enough community care providers to provide timely care for veterans.[4] The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA provided effective oversight of its TPAs and VA medical facilities to ensure facilities had sufficient access to providers through their community care networks. Specifically, the audit team evaluated IVC's oversight of the TPAs' adherence to the following four requirements in the contracts: (1) pre-deployment activities to ensure operational readiness and network adequacy, (2) establishing and maintaining

[1] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018). Under the MISSION Act, veterans are eligible to receive community care under certain circumstances, such as when the veteran's local VA medical facility does not provide the requested service or when a provider determines community care is in the veteran's best medical interest. Consideration is also given to wait times for appointments and the time a veteran spends driving to appointments.

[2] Local VA medical facilities can use veterans care agreements to purchase services that are not available through the CCN. According to a VA website, VA may enter into local veterans care agreements with community providers in limited situations where contracted services through the CCN are either not provided or not sufficient to ensure veterans can get the care they need. Accessed September 9, 2023, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[3] TPAs are contracted entities that manage a network of providers for VHA community care programs. Each of the five contracts began with a base period of one year with seven renewable one-year options, worth a total of up to $86.1 billion.

[4] VHA reported it had integrated its Offices of Veterans Access to Care and Community Care into one office called IVC in July 2022 to help VHA better coordinate care while also streamlining and simplifying access processes. While IVC was the program oversight office at the time of this review, IVC officials noted that the Office of Community Care was the oversight office when the CCN contracts were developed and awarded. In January 2024, VHA reported that IVC is still being fully operationalized.

the network, (3) assessing network adequacy, and (4) network adequacy performance reports.[5] These network adequacy requirements were designed to ensure facilities have enough community providers to administer care to veterans within the timeliness and drive-time standards established in the contract.[6]

What the Audit Found

Although VA established CCN contracts to improve access to community care providers, IVC did not hold TPAs accountable for implementing certain contract requirements designed to ensure facilities have sufficient access to a network of community providers who meet the needs of veterans. IVC's ineffective oversight of TPA performance added to this lapse in contract accountability, which caused staff to struggle to convince TPAs to add community providers to their networks at the eight facilities the audit team visited.

Pre-Deployment Challenges

Despite IVC and TPA leaders claiming the administrators participated in and completed site planning activities, neither party could show evidence demonstrating TPAs fully completed each of the site operational readiness activities outlined in their network adequacy plans. The contracts required TPAs to develop CCN deployment plans that described the strategy for deploying the CCN within each region and VA facility. Specifically, the contracts required plans to contain details on each TPA's strategy to participate in site-readiness planning and deployment activities. TPAs developed and submitted network adequacy plans to IVC for all five regions that listed planned actions for meeting this requirement at each VA medical facility before implementing the contract. These important activities included assessing each facility's demand for community care, reviewing each facility's network, and discussing community care needs with each facility.

During a briefing with IVC leaders in July 2023, the audit team asked IVC to provide evidence showing that TPAs completed these pre-deployment activities or that IVC followed up to make sure these activities occurred. While an IVC leader told the audit team the activities were completed, this leader suggested the audit team meet with IVC's deployment team to obtain documentary evidence. However, IVC's deployment team members said they were not involved in those specific activities and had no evidence to support that they were completed. In addition, TPA leaders from both Optum and TriWest told the OIG they completed the pre-deployment

[5] The contracts require the TPAs to determine network adequacy for each VA facility by specific categories of care and to meet or exceed wait-time and drive-time metrics on 90 percent of consults within each region to receive a "good" rating. TPAs develop monthly network adequacy performance reports for facilities and quarterly network adequacy performance reports for regions that indicate the percentage of healthcare, complementary and integrative health services, dental, and urgent prescription consults that met wait-time and drive-time performance metrics as defined in the contract. See appendix A for additional information on the team's scope and methodology.

[6] For example, the contract states that veterans who live in rural areas and are seeking general care should generally receive care within 30 days and within a 100-minute drive from their home.

activities, but also could not provide evidence to verify this. In January 2024, IVC provided the audit team with documents showing that the TPAs scheduled or held pre-deployment meetings with some facilities to discuss community care needs, but the documentation only showed that the TPAs discussed community care needs with three of the 172 medical facilities, including one that the audit team visited. This documentation did not show evidence that the TPAs assessed each facility's demand for community care or reviewed each facility's network before implementation.

While a lack of evidence alone does not indicate the provider networks were inadequate, the OIG determined that IVC did not ensure TPAs followed contract requirements for facility access to have sufficient providers to meet their demand. Furthermore, IVC did not conduct any analyses of facilities' network adequacy needs to help TPAs build provider networks.[7] As a result, IVC was not positioned to identify and address potential network adequacy challenges that may have ensured facilities had better access to provider networks upon implementation.

Ineffective Oversight of Network Adequacy

IVC did not ensure TPAs maintained provider networks that were accepting VA patients. Medical facility staff at each of the eight facilities the audit team visited reported that many providers in VHA's Provider Profile Management System (PPMS)—VHA's master database of community care providers—were not accepting VA patients.[8] TPAs generally used providers from their existing healthcare portfolios to build VHA's provider networks without verifying the providers' contact information was accurate or that they would accept VA patients. Facility leaders and staff from the eight facilities visited said they were frustrated by the amount of inaccurate information in PPMS, such as addresses, phone numbers, and fax numbers, and that they identified many providers in PPMS who were not accepting VA patients. They further told the audit team that TPAs rarely fixed these inaccuracies in their own provider repositories, which populated information into PPMS daily, because TPAs required the providers to contact their administrator directly to make changes or request removal from the network.

IVC did not know the extent to which providers in PPMS were accepting VA patients because it did not require facilities to annotate that status in PPMS; further, IVC did not effectively monitor the accuracy of PPMS itself or ensure TPAs took action to address provider inaccuracies, resulting in a disconnect between TPAs and medical facilities. The inaccuracies within PPMS prevented IVC and facilities from effectively justifying their needs for additional providers to

[7] VHA Directive 1217, *VHA Central Office Operating Units,* September 10, 2021; The directive requires VHA program offices, such as IVC, to communicate with internal and external stakeholders and be responsive to local needs, including addressing issues identified by local offices.

[8] The contracts state that TPAs must always maintain a network of providers and practitioners that will extend across the entirety of each CCN region and must always be sufficient in numbers and types of providers. The contracts also state that the CCN must always be adequate in size, scope, and capacity to ensure that veterans receive timely care.

TPAs. In addition to inaccuracies within PPMS, IVC did not require TPAs to identify or detail the specialty procedures each provider offered within their provider repositories. For example, not every dermatologist listed in PPMS performed a surgical procedure used to treat skin cancer. An IVC leader said PPMS could not be updated or enhanced to include procedures. This system limitation prevents IVC and TPAs from being able to fully evaluate whether facilities had sufficient access to providers for all services and procedures.

Facility staff were frustrated by the PPMS limitations and the disconnect between TPAs and medical facilities about which providers were accepting VA patients. Facility leaders and staff said their assigned TPA generally did not approve requests to add more specialty services, especially after facilities asked for the first time. Staff said TPAs responded that the facilities had access to enough providers, even though the audit team determined, through interviews with facility leaders and staff, that the list TPAs used to evaluate whether facilities had a sufficient number of providers was unreliable. These issues occurred because IVC did not develop a mechanism for facilities to collect and report challenges with access to specialty care services, including for specific procedures; it did not hold TPAs accountable for ensuring facilities had sufficient access to those services as required by the contract; and it did not fully develop a process to help facilities justify their needs for additional providers.[9]

Ineffective Performance Measurement Tools

IVC did not position itself to defend facilities' needs for additional community care providers. TPAs developed monthly network adequacy performance reports and quarterly network adequacy performance reports in accordance with the contract, but the reports were not an effective means for IVC and facilities to ensure network adequacy for all specialty services and to identify potential gaps in coverage.[10] Specifically, these reports were an ineffective oversight tool because the monthly and quarterly reports combined wait- and drive-time metrics into groupings of care (e.g., primary care and specialty care) rather than creating separate metrics for all relevant specialty care services (e.g., cardiology and neurology), and the quarterly reports combined performance of all of the facilities into the five regions.[11] Therefore, these reports did not provide enough detail to identify potential network adequacy challenges for a specific service or facility, and issues within any specific services could go undetected.

Although IVC launched the Advanced Medical Cost Management Solution (AMCMS) network adequacy suite in October 2022—more than three years after the contract was implemented—it was still completing its first validation of TPA regional quarterly network adequacy performance

[9] VHA Directive 1217; IVC is responsible for "communicating with internal and external stakeholders" and being responsive to "local needs, addressing issues identified by local offices."

[10] These reports are developed in accordance with the contract deliverables.

[11] The contracts require Optum and TriWest to determine network adequacy for each VA facility by specific categories of care and requires them to meet or exceed specific timeliness metrics.

reports as of December 2023 and had not used the tool to conduct routine assessments of facility-level network adequacy.[12] IVC also had not trained relevant facility staff on how to use AMCMS. For these reasons, the OIG did not assess the reliability or effectiveness of the AMCMS tool. Until IVC fully implements and trains staff on AMCMS or develops an alternative mechanism to assess network adequacy, inadequate networks may go unidentified, and facilities may have to continue to request additional providers from TPAs, which was often unsuccessful during prior attempts.

What the OIG Recommended

The OIG made the following recommendations to the under secretary for health to ensure the Office of Integrated Veteran Care

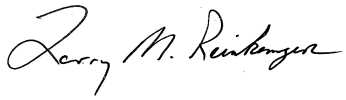
1. Holds future third-party administrators accountable for operational readiness and provider network adequacy at each facility by the time the contracts are implemented.
2. Develops a process to make sure the third-party administrators regularly update their Community Care Network provider lists to reflect accurate provider contact information and annotate providers who are not currently accepting VA patients.
3. Develops a mechanism for facilities to effectively report, track, and monitor challenges with access to specialty care services; trains all relevant staff on how to use the mechanism; make sure facilities use the mechanism routinely; and then helps facilities resolve access challenges.
4. Develops and communicates to facilities a standard process to request and document their needs for additional providers.
5. Evaluates the effectiveness of the third-party administrators' quarterly and monthly reports for assessing network adequacy and then, if needed, modifies the language in its current contracts and makes changes to the applicable contract language for future Community Care Network contracts.
6. Develops its own network adequacy performance reports for each facility and communicates the results to the facilities monthly.
7. Conducts Advanced Medical Cost Management Solution training for community care staff at each facility on evaluating network adequacy through the tool.
8. Routinely evaluates the third-party administrator's network adequacy performance reports to ensure the reports are sufficiently reliable and comply with contract

[12] AMCMS performs several types of analyses related to wait-time and drive-time thresholds for the CCN contracts, assesses network adequacy at a regional and facility level, and provides insight into the specific claims that cause fluctuation in wait and drive times.

requirements, and then holds third-party administrators accountable for resolving identified issues.

VA Management Comments and OIG Response

The under secretary for health concurred or concurred in principle with all recommendations and requested that recommendations 4, 6, and 7 be closed. Further, while VHA's proposed corrective measures for seven of the OIG's eight recommendations are fully responsive to their intent, the actions proposed for recommendation 2 are only partially responsive, as they do not specify how IVC will hold the TPAs accountable for regularly updating their CCN provider lists to reflect accurate provider information. Regarding recommendations 4, 6, and 7, VHA will need to provide additional evidence that the steps described in the action plan were taken before a consideration for closure can be made. The full text of the under secretary's comments appears in appendix B.



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Contents

Abbreviations

AMCMS	Advanced Medical Cost Management Solution
CCN	Community Care Network
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
PPMS	Provider Profile Management System
TPA	third-party administrator
VISN	Veterans Integrated Service Network
VHA	Veterans Health Administration

Introduction

The VA MISSION Act of 2018 consolidated several community care initiatives into one permanent program, known as the Veterans Community Care Program.[13] Since the consolidation, the Veterans Health Administration (VHA) may purchase care for veterans through Community Care Network (CCN) contracts or veterans care agreements. VHA uses the CCNs to purchase care for veterans in their community, while veterans care agreements can be used by local VA medical facilities for services that are not available through the CCN.[14] The CCN groups VA medical facilities into five regional networks managed by two third-party administrators (TPAs)—Optum for regions 1, 2, and 3, and TriWest for regions 4 and 5—that VA contracts with to purchase care for veterans from community providers.[15] The CCN is designed to improve care coordination and make it easier for community providers and VA staff to deliver care to veterans by expanding healthcare services and improving customer service, the exchange of health information, and the referral and scheduling processes.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA provided effective oversight of its TPAs and VA medical facilities to ensure facilities had sufficient access to providers through their community care networks.

Community Care Eligibility

Under the MISSION Act and related VA regulations, veterans are eligible to receive community care in multiple circumstances, including the following:[16]

- The veteran's local VA medical facility does not provide the requested services.
- The veteran lives in a US state or territory without a full-service VA medical facility.
- The service line at the local VA medical facility does not meet specific quality standards.

[13] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[14] According to a VA website, VA may enter into local veterans care agreements with community providers in limited situations where contracted services through the CCN are either not provided or not sufficient to ensure veterans can get the care they need. Accessed August 2, 2023, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[15] Third-party administrators are contracted companies that manage a network of providers for VHA community care programs. Each of the five contracts began with a base period of one year with seven renewable one-year options, worth a total of up to $86.1 billion.

[16] VA MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. § 17.4010 (2023); 38 C.F.R. § 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019. Accessed August 2, 2023.

- The veteran's referring provider, with agreement from the veteran, determines community care is in the veteran's best medical interest.
- The veteran must drive at least 30 minutes for primary care, mental health care, or noninstitutional services, or 60 minutes for specialty care to get to a VA medical facility.
- The veteran's wait time for an appointment at a local VA medical facility or clinic is more than 20 days for primary care, mental health care, or noninstitutional services, or 28 days for specialty care.

Process to Schedule Community Care Appointments

According to VHA, a clinical consult is a request for clinical services created by a physician or other healthcare provider on behalf of a patient seeking an opinion, advice, or expertise regarding evaluation or management of a specific patient problem.[17] Once a consult is made, facility staff such as clinicians, nurses, or schedulers, determine whether the veteran is eligible for community care based on MISSION Act eligibility criteria. If a veteran is eligible for community care, facility staff are required to explain the options of receiving care within VA or in the community by sharing key information, such as wait times, to help the veteran choose their preferred option.[18] If the veteran opts for community care, facility staff ascertain the veteran's community care preferences, such as specific care providers, days, and times, and forward the consult to the community care department for scheduling.

Once the community care department receives the consult, a scheduler should verify the veteran's eligibility for community care.[19] If the veteran is eligible, the community care scheduler checks to see if the veteran has a preferred provider. If the veteran's preferred provider is not an option—for example, the provider is not accepting VA patients or does not perform the needed procedure—then a scheduler can access VHA's Provider Profile Management System (PPMS) to identify other potential community providers.[20] Once a community care scheduler confirms the community provider accepts VA patients and performs the necessary care, the scheduler then either provides the veteran with information needed to schedule their own appointment or schedules the appointment for the veteran.[21]

[17] VHA Directive 1232(5), *Consult Processes and Procedures*, December 5, 2022.

[18] *Office of Community Care Field Guidebook*, sec. 2.0.

[19] *Office of Community Care Field Guidebook*, sec. 2.9.

[20] PPMS is VHA's master database of community providers. According to VHA, PPMS was deployed nationally at the end of fiscal year 2018.

[21] *Office of Community Care Field Guidebook*, sec. 3.16. IVC created a voluntary process in October 2020 to give veterans the option to schedule consults directly with community care providers by using a self-scheduling process. According to the Office of Community Care Field Guidebook, "VSS [veteran self-scheduling] begins once a Veteran indicates he/she would like to schedule their appointment directly with the community provider."

TPA Provider Repositories and VHA's Provider Data Systems

TPAs maintain certain information about CCN providers in their own data repositories. This information, which includes the provider's name and contact details, services they are authorized to perform, credentialing status, and recredentialing due date, is synchronized daily to VHA's PPMS. VHA does not have direct access to either TPA repository.

According to an official from VHA's Office of Integrated Veteran Care (IVC), medical facility staff should use PPMS to identify community care providers available to see VA patients. If facility staff determine that information in PPMS is inaccurate or that providers are no longer accepting VA patients, they lack the capability to edit or remove entries in PPMS. Instead, facility staff must rely on TPAs to correct inaccurate information in their provider repositories.

Based on information from an IVC leader and TPA leaders, the audit team determined the following process to update PPMS:

1. A facility identifies a provider who no longer accepts VA patients.
2. Facility staff cannot edit any data fields or remove this provider from the database, but they can annotate in PPMS when a provider stops accepting VA patients, the reason why, and other relevant information.
3. IVC sends that information to the TPAs for further review and to make changes to the provider repository as appropriate, which is later synchronized to VHA's PPMS. However, IVC has no effective way to verify whether TPAs have taken steps to address VHA's concerns. For example, while IVC could search for a specific provider in PPMS to determine whether the TPA removed the provider from the list, this process would be very time-consuming and would not identify those instances when TPAs disagreed with a facility's request to remove a provider.

According to TPA officials, the administrators will only update their provider repositories when a provider submits updated contact information or confirms they no longer want to be part of the network. Otherwise, TPAs consider those providers active participants in the network and available to the facilities.[22]

An IVC leader said that, in addition to PPMS, VHA began using its Advanced Medical Cost Management Solution (AMCMS) to perform several types of analyses related to wait- and drive-time thresholds for the CCN contracts, assess network adequacy at regional and facility levels, and provide insight into the specific claims that cause fluctuation in wait and drive

[22] The OIG did not conduct a full assessment of VHA's PPMS. The audit team focused on how limitations within PPMS impacted users' ability to identify available community providers. In March 2022, the Government Accountability Office (GAO) published a report that identified vulnerabilities with PPMS, such as active community providers listed in PPMS who were not actually available to see veteran patients. GAO, *VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers*, GAO-22-105831, March 30, 2022.

times.[23] AMCMS also allows users to filter by, for example, locality and specialty care services to measure the approximate wait time from the referral creation date to the first date of service. Users can also view appointment demand versus appointment availability in each locality. This information allows users to determine if parameters set by VA standards are being met. Overall, AMCMS allows stakeholders across VA, VHA, Veterans Integrated Service Networks (VISNs), and VA medical facilities to monitor and identify cost and utilization trend anomalies, track budget execution, and predict future utilization and expenditures.

Oversight of Network Adequacy: Roles and Responsibilities

The CCN contracts outline how VHA and each TPA should determine and measure network adequacy and how they should assist facilities experiencing challenges with provider network adequacy. In addition, VHA Directive 1217 outlines oversight roles and responsibilities of VHA program offices in general.[24] The audit team relied on the contracts and the directive to assess how Optum and TriWest determined network adequacy for VA medical facilities and whether they assisted facilities that experienced challenges with provider adequacy. The team also assessed whether VHA held TPAs accountable for implementing certain contract requirements designed to ensure facilities had sufficient access to a network of community providers.

Community Care Network Contract Requirements

Optum and TriWest are required to determine network adequacy for each VA facility located in the awarded CCN region and by specific categories of care. The audit team evaluated VHA's oversight of the TPAs' adherence to four network adequacy requirements in the contracts.

The contracts required the following:

- **Pre-deployment Activities to Ensure Operational Readiness and Network Adequacy.** TPAs must take part in site-readiness planning and deployment activities to ensure operational readiness and adequate provider networks.

[23] AMCMS is a data analytics platform used to forecast, monitor, and control community care's medical service costs. AMCMS also includes a range of metrics and key performance indicators related to utilization management, such as average cost per encounter, referral volumes, and rendering provider utilization.

[24] VHA Directive 1217, *VHA Central Office Operating Units,* September 10, 2021, sets forth the roles, responsibilities, and decision rights for VHA principle and program offices.

- **Network Establishment and Maintenance.** TPAs must maintain a provider network for each CCN region that has sufficient numbers and types of providers, practitioners, and facilities to ensure that all services are accessible within the contract's time frames.[25]
- **Assessing Network Adequacy.** TPAs must achieve network adequacy through two primary factors:
    - Geographic accessibility to a provider based on drive times
    - Appointment availability

  If network adequacy is not achieved through both factors, TPAs must recruit providers and practitioners actively practicing in that area to participate in the network.
- **Network Adequacy Performance Reports.** TPAs must provide these reports during monthly meetings with each VA medical facility and quarterly to IVC as a record of performance.[26] These reports should include performance deficiencies.

In addition, the Quality Assurance Surveillance Plan requirements for each of the contracts identifies performance objectives, metrics, and requirements for measuring performance.[27] Each plan specifies that performance scores are calculated based on four service areas: primary care, general care, complementary and integrative care, and dental care. The Quality Assurance Surveillance Plans also detail steps for TPAs to take when developing their network adequacy performance reports, such as which dates to use when calculating wait times and which consults to remove from the population. The plans also state that performance will be measured by the facility and then compiled to generate regional network adequacy performance reports.

[25] According to the contracts, TPAs must maintain provider networks that are "adequate in size, scope, and capacity" to make sure veterans receive care in a timely manner. The drive-time and wait-time standards both vary by veteran location (i.e., urban, rural, and highly rural); drive-time standards also vary by type of care (i.e., primary care and general care), and wait-time standards also vary by emergency, urgent, and routine consults. For example, drive times for general care vary from 45 minutes for veterans located in an urban area to 180 minutes for veterans located in a highly rural area. Wait-time standards are 24 hours for emergent care, 48 hours for urgent care, and 30 days for routine care. According to language in the Optum contract, general care is "All other care and services offered under VA Health Benefit Package other than Primary Care and complementary and integrative health services."

[26] The contracts require Network Adequacy Performance Reports to include five elements for all types of provided health care: (1) the average drive time, based on the distance between a veteran's address and the provider's, for each received claim; (2) average appointment wait times, calculated using the date VA sent the referral to the provider to the actual appointment date of the first claim for that referral; (3) any other information concerning rescheduled, canceled, missed appointments, and/or veteran or provider complaints about drive time or appointment availability; (4) any network adequacy gaps based on average drive times and appointment availability and organized by service category and geographic location; and (5) documentation of any appointments that were rescheduled, canceled, or missed.

[27] Quality Assurance Surveillance Plans are documents that government personnel use to assess contractor performance on each contract objective.

Office of Integrated Veteran Care Responsibilities

Within VHA, IVC is responsible for overseeing veteran access to VA and community care, including the execution of the CCN contracts.[28] Within IVC, the Integrated External Networks group leads, develops, and administers the CCN contracts, which includes overseeing the execution of the contracts to make sure Optum and TriWest provide an adequate network and access to timely and quality care for VA patients. IVC's network adequacy oversight office, which is part of Integrated External Networks group, is responsible for ensuring that each VHA medical facility has access to enough community providers to ensure timely care for their veterans. An IVC leader said that staff within the network adequacy office are tasked with evaluating performance metrics and provider availability, as well as providing training to the community care staff at the facilities on tools and policy developed by IVC. As of July 2023, the director of IVC's network adequacy office said her office had nine staff and two vacancies.

VHA Directive 1217 requires VHA program offices, such as IVC, to be responsible for

- adopting evidence-based strategies based on population needs;
- overseeing consistent implementation and systematically identifying risks and unintended variances;
- communicating with internal and external stakeholders and responding to local needs, addressing issues identified by local offices;
- documenting all identified deficiencies and ensuring corrective actions are taken;
- ensuring performance within their span of control; and
- evaluating the effectiveness of outcomes and efficiency of outputs, to include assessing the accuracy of data used for such evaluation.[29]

To comply with the directive, IVC is responsible for identifying potential risks within each facility's network of community providers, ensuring any issues are resolved, and ultimately ensuring medical facilities have access to a sufficient network of community care providers.

Contracting officers are responsible for ensuring the performance of all necessary actions for effective contracting, monitoring compliance with the terms of the contract, and safeguarding the

[28] VHA reported it had integrated its Offices of Veterans Access to Care and Community Care into one office called IVC in July 2022 to help VHA better coordinate care while also streamlining and simplifying access processes. While IVC was the program oversight office at the time of this review, IVC officials noted that the Office of Community Care was the oversight office when the CCN contracts were developed and awarded. In January 2024, VHA reported that IVC is still being fully operationalized.

[29] VHA Directive 1217, *VHA Central Office Operating Units*, September 10, 2021, Section 5 "Responsibilities," Subsection c "VHA Program Office."

interests of the United States in its contractual relationships.[30] Contracting officers can delegate their authority to perform certain contract administration duties in writing to a designated contracting officer's representative. One of the CCN contracting officers told the audit team that her job is to manage the contract by ensuring the TPA adheres to its conditions. This contracting officer said she uses functional contracting officer's representatives to provide oversight, including verifying deliverables are met.

For the CCN contracts, an IVC leader said the contracting officer's representative responsibilities fall under IVC's Contracts Management and Performance office under its Integrated External Networks group. The Contracts Management and Performance office director for regions 2 and 3 said the contracting officer's representatives will review the deliverables from TPAs and provide them to the network adequacy office. This office will then validate and accept the TPAs' deliverables, such as those related to the four network adequacy requirements listed previously, or request that the TPAs resubmit the deliverables.

[30] FAR 1.602-2, September 2023. The contracting officers for the TPA contracts work for VA's Strategic Acquisition Center.

Results and Recommendations

Finding: IVC Efforts to Ensure Facilities Had Sufficient Access to a Network of Community Providers Lacked Accountability and Oversight

The OIG determined that IVC did not hold TPAs accountable for implementing certain contract requirements designed to ensure facilities had sufficient access to a network of community providers. IVC's ineffective oversight of TPA performance added to this lapse in contract accountability, which caused staff to struggle to convince TPAs it was necessary to add community providers to their networks at the eight facilities the audit team visited.

Despite IVC and TPA leaders claiming the administrators participated in and completed site planning activities, neither party could show evidence demonstrating the TPAs fully completed each of the site operational readiness activities outlined in their network adequacy plans.[31] Though a lack of evidence is not proof the provider networks were inadequate, the OIG determined through interviews with facility leaders and staff that IVC did not ensure TPAs followed contract requirements to make sure facilities had access to enough providers to meet demand. Additionally, IVC did not ensure TPAs routinely maintained a network of providers who were accepting VA patients. In particular, medical facility staff at the eight facilities the team visited reported that many of the providers listed in PPMS were not accepting VA patients.[32] IVC also did not position itself to defend facility needs for additional providers because it did not know the extent to which providers in PPMS were accepting VA patients.

Furthermore, while TPA network adequacy performance reports complied with the terms of the contracts, the reports were not an effective oversight tool for IVC and facilities to evaluate network adequacy or identify potential gaps in coverage because they lacked key information, such as appointment availability and drive-time metrics for specific specialty services that would help leaders identify network deficiencies.[33] IVC did not have a consistent mechanism or process

[31] According to the CCN contracts, TPAs must develop deployment plans that contain details on their method to participate in site readiness planning and deployment activities to ensure operational readiness and provider network adequacy.

[32] The contracts state that TPAs must always maintain a network of providers and practitioners that will extend across the entirety of each CCN region and must always be sufficient in numbers and types of providers. However, TPAs did not generally remove providers from their repositories even after receiving reports of providers who stopped accepting VA patients.

[33] The contracts require Optum and TriWest to determine network adequacy for each VA facility by specific categories of care and requires Optum and TriWest to meet or exceed specific timeliness metrics. To do so, TPAs develop monthly network adequacy performance reports for facilities and quarterly network adequacy performance reports for regions that indicate the percentage of healthcare, complementary and integrative health services, dental, and urgent prescription consults that met wait- and drive-time performance metrics as defined in the contract. These reports are developed in accordance with the contract deliverables.

to evaluate facility needs for providers or verify the accuracy of TPA reports on network adequacy. Though IVC began using its own system, the AMCMS, to assess network adequacy, IVC was still completing its first validation of the TPA quarterly network adequacy performance reports as of December 2023—more than four years after the first CCN contract was awarded—and had not used the tool to conduct routine assessments of network adequacy at the facility level, nor had IVC fully trained facility staff on how to use the system. These conditions present the risk that insufficient networks may go unidentified, and facilities may continue to struggle to convince TPAs to add more providers to their network.

The following deficiencies support the OIG's finding:

- IVC did not hold TPAs accountable for contract requirements designed to ensure facilities had sufficient access to a network of community providers.
- Network adequacy performance reports were an ineffective oversight tool, and IVC did not routinely conduct its own evaluations of network adequacy.

What the OIG Did

The audit team conducted about 120 interviews with leaders and staff at VHA's IVC, VA's Strategic Acquisition Center, TriWest, Optum, and six VISNs and eight medical facilities. The team conducted site visits to the following eight VA healthcare systems: Louis Stokes (Cleveland, Ohio), Togus (Augusta, Maine), Fayetteville Coastal (North Carolina), Alvin C. York (Murfreesboro, Tennessee), Royal C. Johnson (Sioux Falls, South Dakota), Fort Harrison (Fort Harrison, Montana), Audie L. Murphy (San Antonio, Texas), and the Colonel Mary Louise Rasmuson campus of Alaska (Anchorage). Appendix A provides additional information about the team's scope and methodology.[34]

IVC Did Not Hold TPAs Accountable for Contract Requirements Designed to Ensure Facilities Had Sufficient Access to a Network of Community Providers

Although the TPAs developed network adequacy plans listing actions they would take to ensure operational readiness and provider network adequacy at VHA's medical facilities, neither IVC nor the TPAs could provide evidence the administrators fully completed those actions prior to implementing the CCN contracts. In addition, VHA staff said, and TPAs confirmed, that TPAs generally used providers from existing healthcare portfolios to build the CCN; however, TPAs did not verify the accuracy of the provider information. As a result, facility leaders and staff experienced frustration as they discovered many of the providers listed in PPMS no longer accepted VA patients, and those who did often had inaccurate contact information. Additionally,

[34] The audit team selected at least one facility from each of the five regions.

IVC did not require TPAs to identify or detail the procedures each specialty service provider offered, making it harder for staff to find providers who performed the specific procedures the veterans needed. As facility staff identified these inaccuracies and limitations, they also identified the need for additional community providers. However, because TPAs based their assessments of network adequacy on inaccurate lists of providers, they often denied facility requests to add more providers to address network adequacy challenges.

No Evidence Showing TPAs Completed Pre-Deployment Activities

The contracts require TPAs to develop plans that describe the strategy for deploying the CCN within each region and VA facility, including details on the TPAs' performance of site-readiness and deployment activities to ensure operational readiness and adequacy of provider networks. Prior to implementation, the TPAs developed and submitted these plans to IVC for all five regions.[35] These plans committed TPAs to complete the following actions prior to implementation:

- Assess each facility's demand for community care.
- Review each facility's network before implementation.
- Discuss community care needs with each facility.

In July 2023, the audit team asked IVC leaders to provide evidence showing that TPAs completed these pre-deployment activities or that IVC followed up to make sure the activities occurred. While an IVC leader told the audit team the activities were completed, this leader suggested the audit team meet with IVC's deployment team to obtain documentary evidence. However, IVC's deployment team members said they were not involved in those specific activities and had no evidence to support they were completed. In January 2024, IVC provided the audit team with documents showing that the TPAs scheduled or held pre-deployment meetings with some facilities to discuss community care needs, but the documentation only showed that the TPAs discussed community care needs with three of the 172 medical facilities, including one that the team visited. This documentation did not show evidence that the TPAs assessed each facility's demand for community care or reviewed each facility's network before implementation.

In addition, neither Optum nor TriWest could provide the audit team with evidence it completed these actions. Optum reported, "Prior to the deployment of each phase, a comprehensive geographical analysis was also conducted to identify the existing provider footprint and Veteran population. Engagement with VA facilitated the collection of additional insights, provider preferences, and any existing challenges specific to these catchments." However, Optum could

[35] According to the CCN contract, the CCN deployment plans were required to be submitted "[f]ifteen (15) days after kickoff meeting and updated monthly thereafter until completion of deployment."

not provide evidence to show that these activities occurred, or how they were used to ensure operational readiness and provider network adequacy. When the audit team asked TriWest to provide an example of the site-readiness activities completed for one of the facilities within region 4, TriWest sent the team a PowerPoint presentation that further detailed its plans for pre-deployment. However, TriWest could not provide evidence that it completed any of the three pre-deployment actions listed in its network adequacy plans.

Because IVC did not verify that TPAs fully completed each of the pre-deployment actions or develop its own process to ensure facilities had access to sufficient provider networks prior to implementing the CCN contracts, the office was not positioned to identify potential challenges with network adequacy. Without these measures in place, IVC cannot hold future TPAs accountable for ensuring operational readiness and provider network adequacy.

During the OIG's interim briefing with IVC leaders in July 2023, an IVC leader said that not all relevant actions had been taken prior to the contract being implemented and that IVC learned some lessons as it relates to contract implementation and satisfying the pre-deployment requirement. The leader said IVC will be discussing these issues and identifying possible solutions during upcoming network planning meetings. A different IVC leader said during the same briefing that there are opportunities to improve the language related to this implementation requirement in future community care contracts.

Unreliable Community Provider Lists Led to Frustration Among Facility Leaders and Staff

According to the contracts, TPAs must maintain sufficient numbers and types of providers for each CCN region. While building the CCN, TPAs added community providers without confirming the accuracy of contact information or whether they would accept VA patients, limiting TPAs' ability to ensure the numbers and types of community providers were sufficient to support VHA's medical facilities. For example, Optum reported that its "network strategy involved engaging providers with existing Optum/UnitedHealthcare Network and VA relationships."[36] TriWest told the audit team that it "already had networks prior to CCN so many providers were amended into CCN" and the "pre-existing relations … enable us to add to the network more quickly based on that existing familiarity and because the network subcontractors have already completed credentialing for those providers."

Neither the IVC nor TPAs could provide the audit team with evidence that TPAs generally verified that provider contact information was accurate, or that the providers would accept VA patients. When the audit team asked Optum whether it contacted each provider before adding the provider to the CCN, the TPA reported, "In cases where a provider was already contracted for another line of Optum business, pertinent information regarding CCN was provided alongside

[36] UnitedHealthcare is the health benefits business of UnitedHealth Group, which includes Optum.

the relevant contract amendment." When asked if it tracked and monitored contact attempts with providers, including any providers who said they did not want to be part of the network, Optum responded that it "does not have documentation to provide." When the audit team asked whether TriWest contacted each provider before adding the provider to the CCN, the TPA reported that, "providers were given welcome letters and many outreach campaigns were done to raise awareness of the forthcoming CCN program. Admittedly there were providers who missed these notifications." When asked if it tracked and monitored contact attempts with providers, including any providers who said they did not want to be part of the network, TriWest responded that it "did track contact attempts during the implementation phase, but that documentation has not been retained."

Facility leaders and staff from the eight facilities the audit team visited told the OIG they were frustrated by the amount of inaccurate information in PPMS, such as addresses, phone numbers, and fax numbers, which were often reported to be "999-999-9999." These inaccuracies impacted both staff and VA patients. A scheduler in Sioux Falls reported that inaccurate information in PPMS is one of the biggest roadblocks to scheduling. The scheduler said that, for example, it has taken him over two hours to find a provider for a specific service that accepted VA patients. Another scheduler in Anchorage reported that patients have been sent to the wrong address for appointments because the provider address in PPMS was inaccurate. This scheduler also noted that authorizations, which staff send to community care providers before care is provided, are sent to the wrong location if fax numbers are not updated.

Medical facility staff at all facilities visited reported that many of the providers listed in PPMS were not accepting VA patients. For example, the Fort Harrison facility tested the accuracy of PPMS by evaluating the extent to which all 489 dental providers listed in the system were accepting VA patients. The test revealed that only 58 providers (12 percent) were accepting VA patients in varying capacities: 45 providers were accepting new VA patients and 13 were accepting only established VA patients. Facility staff also determined that 196 of the 489 dental providers (about 40 percent) were duplicate entries.[37]

An IVC leader said, and TriWest and Optum leaders confirmed, that the TPAs had their own systems to track and monitor community providers in their repositories who were part of VHA's network, and that those repositories populated PPMS. However, the audit team determined that neither IVC nor facility staff have control over if or when TPAs will update incorrect provider information in their repositories. Facility staff said they also cannot update PPMS to edit or remove inaccurate provider information. Instead, facility staff reported, and TPA leaders confirmed, that community care providers must contact the TPA (or be contacted by the TPA) to confirm information needed to be changed in the provider repositories. Otherwise, TPAs consider those providers active participants in the network and available to the facilities. The

[37] The audit team did not independently verify the results of this facility's evaluation.

audit team determined this process was not formally documented or communicated to the facilities.

Facility leaders and staff told the audit team that TPAs rarely fixed inaccurate provider contact information. An IVC leader said that she does share PPMS inaccuracies, such as incorrect contact information and unavailable providers, with TPAs when facility staff note issues in PPMS. However, facility staff are not required to document issues with PPMS, and this IVC leader admitted that not all staff report on issues with PPMS. Unless IVC requires facilities to use PPMS to document inaccuracies and then ensure TPAs take appropriate action to resolve potential issues, PPMS will likely remain a system that facility staff cannot trust or use to schedule VA patients for community care in an efficient manner.

IVC did not effectively track and monitor the availability of providers within PPMS or develop a process to require that facility staff do so. An IVC leader agreed there was a disconnect between the facilities and TPAs regarding which providers were and were not accepting VA patients. Additionally, an Optum representative stated that "not accepting patients" can mean a few things: it may be that a provider does not have the availability to accept patients now but will in the future, or the provider may no longer want to participate in the network. Unfortunately, when IVC notified TPAs of providers who facility staff said were not accepting VA patients, IVC did not require TPAs to determine and report back as to whether the providers were not accepting VA patients now but may in the future or had no plans to accept VA patients and wanted to be removed from the CCN. Without that information, IVC is not positioned to provide adequate support to facilities to address issues concerning providers who are not accepting VA patients.

Facilities Struggled to Convince TPAs to Add Community Providers

Facility leaders and staff reported that their TPA did not generally approve requests to add more specialty services unless they made multiple attempts to justify their needs after initial resistance, and even those additional attempts were not always successful. IVC was unable to provide the audit team with any standard operating procedures, templates, or tools that were available for facility leader and staff use when requesting a TPA add a provider to the CCN. Requests could be submitted during routine network adequacy meetings, via email, or through TriWest's Demand Capacity Tool.[38] Even though IVC informed the audit team this tool was developed to address facilities' concerns, facility leaders and staff said TriWest did not always add providers to the network, citing that TriWest relied on their inaccurate provider repositories to determine whether facilities were using all network providers. Optum did not have its own system or tool for facility staff to formally request additional providers be added to the network.

[38] According to IVC, TriWest's Demand Capacity Tool allows VHA staff to request that the TPA add additional providers for certain services.

IVC did not track the number or frequency of each facility's requests for additional providers, and the audit team determined it would be difficult to do so without a standardized process to make those requests. VHA Directive 1217 requires IVC to oversee "consistent implementation" which, in this instance, could include the development of procedures, templates, or tools to ensure community care staff use the same method to report and resolve various challenges.

Staff from several facilities said that although they identified community providers who wanted to join the network, Optum refused to add providers to their repository when it thought facilities already had enough. Facility staff and an Optum leader also reported that the TPA told some community providers it was not accepting applications because it had enough, but that they would be added to a wait list for future consideration. Facilities under TriWest also had challenges convincing the TPA to add providers. For example, staff at San Antonio said TriWest would generally send their facility a list of underutilized providers from its system to highlight those the facility had not used, and then the facility either added the providers to their own lists or noted any barriers to use, for example, if they were not accepting VA patients.

The fact that the TPAs did not have reliable provider lists has significant consequences. Based on interviews with facility staff, TriWest did not generally reach out to facility staff to find out why they were requesting additional providers, or to find out why the network providers were not sufficient, and instead continued to send the facilities lists from a system that contained providers who were not accepting VA patients. The San Antonio facility's community care chief said TriWest may send lists of underutilized providers to the facility on a routine basis or in response to the facility's request for additional providers. A scheduling supervisor from the same facility gave the audit team an example of actions he took to analyze one of TriWest's underutilization reports: the report included 627 providers of ophthalmology, optometry, obstetrics and gynecology, primary care, or behavioral health services, and facility staff called each one and determined that only 138 providers (22 percent) were accepting VA patients. The facility did not respond to the audit team's question as to whether the 138 providers satisfied the facility's need because the employee who was involved with this request was on extended leave. However, the chief said the facility still generally needed to request additional providers even after TriWest sent the underutilization lists because the providers who are accepting VA patients may not be near the veterans in need of the service or may only conduct telehealth appointments, which might not be an appropriate method of care.

When TPAs denied a facility's request to add providers, facilities used different approaches to further justify their needs, including providing additional information beyond what is in PPMS. The Fort Harrison community care chief provided an example in which TriWest denied a request for dermatologists because of an already adequate network. The chief resubmitted the request in the Demand Capacity Tool asking for dermatologists who are certified to perform a specific surgical procedure. TriWest subsequently approved the request and told the chief that his request would have been approved initially had he specifically requested dermatologists who performed

the specific procedure. Additionally, the Murfreesboro community care chief said that, after Optum initially denied his request for additional orthopedic providers, he had to further justify the facility's need by showing Optum there was a lack of orthopedic providers who treated knee issues in a specific location of need. The chief said the facility, not the TPA, made the effort to recruit providers outside of the CCN who may be willing to accept VA patients, and then the facility sent that list of potential network providers to Optum so the TPA could add them to the network. Based on these interviews, the additional attempts to convince TPAs to add providers were time-consuming and facilities did not have full-time staff who were dedicated to performing these tasks.

When the audit team asked TriWest and Optum leaders to explain their reasons for not adding more providers to the network, the leaders said this was partly a financial decision, which the OIG determined should not have kept them from complying with the requirements of the contract. In an August 2023 email, TriWest explained that there "are costs to recruit providers, negotiate contracts, process contracts, credential and re-credential providers, maintain data, audit records and educate the network. These costs are both up-front and on-going over the life of the TriWest-Provider relationship. All those costs have incremental increases with each provider added." Similarly, an Optum representative stated it must be financially responsible because there is a cost associated with adding providers, especially if they do not think facilities will use the provider. However, TPAs are contractually obligated to build and maintain an adequate network of community providers regardless of the financial cost to them.[39]

Facility staff were frustrated by the lack of control they had over the process to add providers to their community network. This occurred because (1) IVC did not develop a mechanism for facilities to effectively collect and report challenges with access to specialty care services, including for specific procedures; (2) it did not hold TPAs accountable for ensuring facilities had sufficient access to those services; and (3) it did not fully develop a process and mechanism to help facilities justify their needs for additional providers.[40] According to VHA Directive 1217, IVC was responsible for "communicating with internal and external stakeholders," being responsive to "local needs, addressing issues identified by local offices," and "documenting all identified deficiencies and ensuring corrective actions are taken." Without a better process in place to report network adequacy challenges and justify a facility's needs, facilities will continue to struggle to improve access to various specialty service providers.

[39] The contracts require the TPAs to establish and maintain a network of high-performing licensed healthcare providers as well as healthcare practitioners to deliver patient-centered care. Moreover, where network adequacy is inadequate, the TPAs will be required to recruit providers and practitioners currently practicing to participate in the CCN.

[40] VHA Directive 1217, *VHA Central Office Operating Units,* September 10, 2021. The directive also states that IVC is responsible for "communicating with internal and external stakeholders" and being responsive to "local needs, addressing issues identified by local offices."

Missing Information from VHA's Community Care Provider Database Limited Its Ability to Conduct Comprehensive Needs Assessments

IVC did not require TPAs to identify within their provider repositories which procedures each specialty service provider offered. Additionally, an IVC leader stated that PPMS could not be enhanced to include such information. This system limitation prevents IVC and TPAs from being able to fully evaluate whether facilities had sufficient access to providers for all services and procedures. For example, not every dermatologist listed in PPMS performed a certain surgical procedure used to treat skin cancer. Since this information was not captured, neither IVC nor the TPAs could determine whether facilities had access to enough providers who performed that surgery—or any other specialty procedures—to ensure veterans needing specific procedures could be seen in a timely manner.

To circumvent this limitation and the inaccuracies within PPMS, staff at the eight facilities the audit team visited said they created their own provider lists on spreadsheets, even though IVC wanted staff to use PPMS, as a workaround to the limitations in PPMS. The following are examples showing the lengths staff went to ensure they had accurate and complete information about available community providers:

- A Togus community care administrative manager said facility staff compared the active provider list in PPMS to their internal spreadsheets once a week to identify community providers who may have been added to PPMS. They then used that comparison to ensure their lists contained all available providers.
- Fort Harrison's community care manager said an analyst pulled the list of providers in PPMS daily, highlighted new providers added, called providers to confirm they would accept VA patients, and then facility staff added the accepting providers to their own spreadsheets.
- Cleveland's community care chief said identifying available providers is a continuous process. The chief said the facility did not scrub the entire list at once or analyze PPMS weekly, but they updated their own spreadsheets as they identified other available providers or to remove providers who stopped accepting VA patients.

Creating separate spreadsheets, however, presents the risk that facilities may miss opportunities to schedule patients with newly added community providers or that staff may rely too heavily on certain providers.

All facilities the audit team visited reported using a similar process. PPMS is not a reliable system because it fails to capture all the information staff need to identify available providers. IVC has an opportunity to ensure that a TPA's decision to add more providers and enhancing the network is based on an accurate list of available providers by developing a process to ensure

TPAs maintain accurate lists of providers. Further, IVC should develop its own network adequacy performance reports for each facility, communicate the results to the facilities routinely, and develop guidance for facility staff on how to monitor PPMS for newly added providers. Without these necessary steps, staff will likely continue to use their own spreadsheets as their primary source of provider options.

Network Adequacy Performance Reports Were an Ineffective Oversight Tool, and IVC Did Not Routinely Conduct Its Own Evaluations of Network Adequacy

TPAs developed monthly network adequacy performance reports for facilities and regional quarterly network adequacy performance reports for IVC indicating the percentage of healthcare, complementary and integrative health services, dental, and urgent prescription consults that met wait- and drive-time performance metrics as defined in the contract.[41] TPAs also held monthly network meetings with each facility. TPAs used those meetings to discuss the results of the monthly network adequacy performance reports; however, facility staff said the monthly reports lacked sufficient detail, such as how long patients waited to receive care or how specific specialty services performed, to identify potential gaps of coverage within the network. The quarterly network adequacy performance reports that TPAs sent to IVC combined performance metrics of all the facilities to a regional level, but they did not help IVC identify network adequacy concerns within specific facilities or specialty services. IVC used AMCMS to track and monitor network adequacy.[42] However, an IVC leader said that IVC did not deploy AMCMS until October 2022, more than three years after the initial CCN contract was implemented. The audit team did not assess the reliability or effectiveness of the AMCMS tool because IVC was still developing it and had not provided evidence to show it was used to successfully evaluate the accuracy of TPA network adequacy performance reports or to routinely assess network adequacy at the facility level.

Required Network Adequacy Performance Reports Were Not Designed to Identify Network Adequacy Challenges

The contracts required TPAs to provide VA and its medical facilities with network adequacy performance reports, including any performance deficiencies, but the contracts lacked specificity on the metrics and level of granularity to be reported. As a result, while TPAs generally provided

[41] For example, the contracts state that veterans who live in rural areas and are seeking general care should generally receive care within 30 days and within a 100-minute drive from their home.

[42] VHA uses AMCMS to perform several types of analyses related to wait-time and drive-time thresholds for the CCN contracts, assess network adequacy at a regional and facility level, and provide insight into the specific claims that cause fluctuation in wait and drive times. AMCMS allows users to filter by, for example, locality and specialty care services to measure approximate wait time from the date the referral was created to the first date of service.

monthly network adequacy reports to the facilities in accordance with the contract, these reports provided little value and were not a useful oversight tool for facilities to measure wait times for specific specialty care services, such as cardiology or neurology. One community care chief said TriWest's monthly network adequacy performance reports were extremely hard to understand.

Another community care chief said Optum's monthly network adequacy performance reports were not accurate or helpful. Facility staff told the audit team that TPAs generally ran monthly meetings to go over the reports, but they focused only on the positive outcomes. According to an internal IVC document dated August 2023, IVC intends to adjust future CCN contract language to allow VA facilities to determine discussion topics during network adequacy meetings.

The audit team reviewed a monthly network adequacy report that Optum developed for the facility in Togus, Maine. The report combined almost all specialty services into one overarching category to show Optum's progress toward meeting wait-time metrics. The report showed timeliness metrics were met for 3,374 of the 3,597 community care consults (about 94 percent) that Optum used to calculate its success. While 94 percent exceeds Optum's performance standards, the analysis identified 223 consults that did not meet the timeliness metrics. However, the report did not provide details on those 223 consults, such as which specialty services they were for or how long those veterans waited for care. Thus, Optum's monthly network adequacy performance reports did not explore potential weaknesses within the facility's network. The facility's community care chief reported that veterans were waiting about eight to 18 months to receive gastrointestinal care, about nine to 12 months to get a colonoscopy, and about six months for neurology services—even for some urgent consults. However, one of Optum's monthly network adequacy performance reports indicated the Togus facility had an adequate network and did not identify the risks the chief reported. The limitations of these monthly network adequacy performance reports present the risk that insufficient access to various specialty services at specific facilities may go undetected and unresolved.

TPAs also provided quarterly network adequacy reports on regional performance to IVC that generally complied with contract requirements. Similarly, however, these quarterly reports were not a useful oversight tool for IVC to effectively monitor network adequacy because they did not identify potential gaps in specialty care at various VA medical facilities. Wait- and drive-time metrics were combined at a regional level into groups of consults—healthcare, complementary and integrative health services, dental and urgent prescriptions—due to the way VA wrote the contract.

To improve these conditions, IVC will need to evaluate the effectiveness of TPA monthly and quarterly network adequacy reports for assessing network adequacy and then modify the language in its current contracts or make changes to the applicable contract language for future CCN contracts.

IVC Had No Routine Mechanism to Evaluate Facilities' Needs

IVC did not effectively position itself to defend facilities' needs for more providers against resistance from TPAs, nor did it develop processes or a consistent mechanism to help facilities justify their needs to TPAs. VHA Directive 1217 required IVC to ensure "performance within their span of control." However, until October 2022, IVC did not have a system in place to help facilities monitor whether veterans had sufficient access to various specialty services or procedures. IVC began using AMCMS to track and monitor network adequacy more than three years after the initial CCN contract was awarded, though its capabilities are limited. According to an IVC leader, AMCMS can analyze community care consults only *after* a consult's first episode of care has been completed; it is not capable of using pending consult data to anticipate potential network adequacy challenges. AMCMS also does not calculate wait times for consults that never get scheduled due to an inadequate network of providers.

An IVC network adequacy leader also said IVC does not generally evaluate network adequacy at the facility level unless requested by the facility. Not all facility staff were aware of AMCMS, had been trained on it, or were using it to evaluate network adequacy. In June 2023, an IVC leader said AMCMS training had been completed for numerous sites on an ad hoc basis, but that there was no mechanism in place to track which facilities had received the training. The leader also said that AMCMS training will be conducted across all facilities and that it will track who completed the training.[43] IVC did not provide the audit team with a training schedule or estimate as to when it expected to complete all training. Given the importance of ensuring facilities have access to an adequate network of providers, IVC can strengthen its oversight by developing its own network adequacy performance reports for each facility, and then either routinely share those reports with the facilities or conduct AMCMS training to facility leaders so they can create their own reports to identify network challenges.[44]

IVC Had Not Verified the Accuracy of TPA Network Adequacy Performance Reports

According to an IVC leader, one of the goals of AMCMS was to help IVC ensure the TPAs' network adequacy performance reports were based on accurate consult data and complied with

[43] An IVC leader said this training is part of the Soonest and Best Care Initiative, which, according to VHA, is one of six identified priorities that are foundational in supporting VHA's long-range goals. VHA established three metrics to track the initiative progress: (1) direct care wait times from the date of request for new patient appointments, (2) time to schedule community care appointments, and (3) veteran satisfaction with timely care.

[44] The OIG team did not evaluate the accuracy or effectiveness of AMCMS because at the time of the audit it was a new system still in development and undergoing testing to validate TPA performance reports, and staff had generally not been trained to use it.

the Quality Assurance Surveillance Plans requirements.[45] The OIG determined, and an IVC leader agreed, that the plan allows a TPA to remove a number of consults from their quarterly performance calculations. While the intent of these exclusions is to prevent a TPA's performance metrics from being negatively affected, doing so could also positively inflate timeliness metrics.

As of August 2023—more than four years since the contract was implemented—IVC was unable to provide the audit team with evidence it verified the accuracy and reliability of TPA network adequacy performance reports, such as whether TPAs calculated performance in accordance with their Quality Assurance Surveillance Plans. According to VHA Directive 1217, IVC is responsible for "evaluating the effectiveness of outcomes and efficiency of outputs, to include assessing the accuracy of data used for such evaluation" and "systematically identifying risks and unintended variances." An IVC leader told the audit team that IVC identified discrepancies with network adequacy performance reports by both TPAs that have yet to be reconciled. For example, the leader said IVC determined that Optum had some miscalculations that needed to be corrected to improve its reports. The leader said IVC anticipates that Optum will provide updated quarterly network adequacy performance reports and a response to IVC's validation efforts in August 2023—as of December 2023, IVC had not provided evidence to the audit team to show Optum completed this effort. The IVC leader said efforts to validate TriWest's quarterly network adequacy performance reports will be a much longer process because calculations by each party differed significantly. The leader said IVC is targeting October 2023 to resolve these discrepancies with TriWest—as of December 2023, IVC had not provided evidence to the audit team to show TriWest resolved the discrepancies.

IVC's regional operations manager informed the audit team that the contracting officer's representatives do not assess the accuracy of Optum's network adequacy performance reports but instead act as a facilitator by providing all the information to the IVC network adequacy team for validation. Given the importance of accountability, IVC has an opportunity to improve its oversight of the TPAs' network adequacy performance reports by continuing to validate their reports to ensure the reports comply with contract requirements, and then hold TPAs accountable to resolve identified issues.

Conclusion

While TPAs generally met the contractual requirements for the implementation of the CCN, IVC did not ensure facilities had access to an adequate network of community providers before

[45] The Quality Assurance Surveillance Plans are similar for each of the five CCN contracts and identifies performance objectives, metrics, and requirements for measuring performance. The performance scores are calculated by region and are based on four service areas: primary care, general care, complementary and integrative care, and dental care. According to language in the Optum contract, general care is "All other care and services offered under VA Health Benefit Package other than Primary Care and complementary and integrative health services."

implementation of each contract. This is because IVC did not verify that TPAs fully completed each of the pre-deployment actions from their deployment plans and IVC did not have its own process to ensure network adequacy. Additionally, IVC did not position itself to support the facilities' needs for additional community care providers because IVC did not know the extent to which providers in their database were accepting VA patients or the extent that TPAs used inaccurate provider lists to determine facilities' needs. IVC did not develop a mechanism for facilities to effectively collect and report challenges with access to specialty care services to TPAs and then follow up to ensure resolution. These challenges left facility staff frustrated that their requests for additional providers were not always assessed appropriately based on needs to accurate provider lists.

As of August 2023, IVC had not completed assessments of TPA network adequacy performance reports to validate the accuracy of those reports, although IVC implemented AMCMS in October 2022 to conduct those evaluations, nor had IVC trained facility staff on how to use AMCMS to monitor network adequacy for their own facilities. Further, the TPA quarterly and monthly network adequacy performance reports were not an effective oversight tool to help IVC and facilities identify potential weaknesses within their networks. This limitation presents the risk that inadequate provider networks may go undetected, delaying patient care. The recommendations that follow are meant to help VHA take corrective actions to address the deficiencies outlined in this report.

Recommendations 1–8

The OIG made the following recommendations to the under secretary for health to ensure the Office of Integrated Veteran Care:

1. Holds future third-party administrators accountable for operational readiness and provider network adequacy at each facility by the time the contracts are implemented.
2. Develops a process to make sure the third-party administrators regularly update their Community Care Network provider lists to reflect accurate provider contact information and annotate providers who are not currently accepting VA patients.
3. Develops a mechanism for facilities to effectively report, track, and monitor challenges with access to specialty care services; trains all relevant staff on how to use the mechanism; make sure facilities use the mechanism routinely; and then helps facilities resolve access challenges.
4. Develops and communicates to facilities a standard process to request and document their needs for additional providers.
5. Evaluates the effectiveness of the third-party administrators' quarterly and monthly reports for assessing network adequacy and then, if needed, modifies the language in its

current contracts and makes changes to the applicable contract language for future Community Care Network contracts.

6. Develops its own network adequacy performance reports for each facility and communicates the results to the facilities monthly.
7. Conducts Advanced Medical Cost Management Solution training for community care staff at each facility on evaluating network adequacy through the tool.
8. Routinely evaluates the third-party administrator's network adequacy performance reports to ensure the reports are sufficiently reliable and comply with contract requirements, and then holds third-party administrators accountable for resolving identified issues.

VA Management Comments

VHA's under secretary for health concurred or concurred in principle with all eight recommendations; provided an action plan for each; and requested the closure of recommendations 4, 6, and 7. Appendix B includes the full text of the under secretary's comments, which are summarized below.

To address recommendation 1, IVC intends to use lessons learned from previous contract implementations and industry best practices to develop the next generation of the CCN contract. IVC also intends to create a comprehensive operational plan for the next generation of the contract to make sure TPAs establish and maintain adequate networks for VA facilities.

For recommendation 2, the PPMS data team established a process in January 2024 to perform monthly data comparisons between PPMS and the respective TPA portals. The PPMS data team also enhanced its weekly PPMS training to the field, including the processes for updating provider contact information, adding notes, and flagging providers that have asked to be removed from the network versus those that may temporarily not be accepting new or existing veteran patients. IVC concurred in principle with this recommendation because the TPAs are not contractually required to provide updates regarding providers who currently may not be seeing veterans.

In response to recommendation 3, IVC developed a ticketing system for facility staff to document recurring network access issues when they are not resolved through the monthly meetings with the TPAs. IVC said they plan to follow up on each submitted ticket until the issues are resolved. Additionally, IVC is developing training on the AMCMS Network Management suite to support use of the tool and make sure it is meeting the needs of the facilities.

To address recommendation 4, IVC developed a ticketing system in November 2023 for facility staff to use to document recurring network access issues and to escalate concerns. Training on the ticketing system was completed in November 2023. Additionally, IVC assigned a network analyst to each region who will serve as a liaison between the facilities and the TPAs and address

any ongoing concerns. VHA also reported that it had developed a standard process for requesting additional providers and documenting needs and communicated this process to VHA facilities.

For recommendation 5, in June 2023, IVC started validating reports required by the contracts against AMCMS reports to ensure accurate network adequacy calculations. IVC staff can now validate the reports before accepting a TPA's reported performance. VHA officials stated that IVC concurred in principle with this recommendation because modifying the current contracts is not feasible and would not benefit VA. IVC is developing a comprehensive operational plan that will address VA's roles and responsibilities for network implementation in the next generation of the CCN contract.

In response to recommendation 6, IVC officials reported that staff at each facility were trained on how to use AMCMS to monitor network adequacy based on contract requirements. IVC concurred in principle with this recommendation because the recommendation includes communicating to facilities the results of the network adequacy performance reports on a monthly basis. IVC does not formally do this because AMCMS reports are updated monthly, and approved facility staff can access these reports at any time.

To address recommendation 7, IVC officials reported that staff at each facility were trained on how to use AMCMS to report and monitor network performance, and that the users can perform several types of community care analysis and view appointment demand versus appointment availability.

For recommendation 8, IVC staff worked with the TPAs to make sure they understood the contractual requirements for network adequacy calculations to match between the TPA performance reports and AMCMS. In addition, IVC began validating the quarterly and monthly TPA network adequacy calculations against AMCMS reports in June 2023 and estimates validation will be completed in all regions by June 2024.

OIG Response

The under secretary's planned corrective actions are responsive to the intent of all recommendations, with the exception of recommendation 2. The response to recommendation 2 is partially responsive, as it provides a plan for community care staff in the field. However, the response does not specify how IVC will hold the TPAs accountable for regularly updating their CCN provider lists to reflect accurate provider information. IVC also did not specify how it will make sure facilities are annotating providers who are not currently accepting VA patients.

Furthermore, the under secretary needs to provide additional evidence that the steps described in the action plan were taken before the OIG will consider closing recommendations 4, 6, and 7. For recommendation 4, VHA will need to provide evidence that IVC developed a standardized process for requesting and documenting additional providers and communicated that process to all VHA facilities. For recommendations 6 and 7, IVC must provide evidence to show that

appropriate community care staff at all the facilities have been granted access to the AMCMS network adequacy suite and have been trained on its functionality.

The OIG will monitor VHA's implementation of the recommendations until all proposed actions are completed.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from January 2023 through January 2024. This audit evaluated the Office of Integrated Veteran Care's (IVC) oversight of the third-party administrators (TPAs) and VA medical facilities to ensure facilities had access to an adequate network of providers. The team also determined whether IVC or TPAs effectively collected and resolved issues raised by facility staff related to network adequacy.

Methodology

The audit team identified and reviewed IVC and TPA assessments, contracts, applicable laws and regulations, VA policies and procedures, and processes related to community care network adequacy. The team conducted four interviews and held three interim briefings with IVC leaders who are responsible for oversight of network adequacy at the facility level. The team also conducted interviews with eight VISN leaders who were responsible for overseeing network adequacy at each of the eight facilities the team visited. Furthermore, the team conducted more than 90 interviews of leaders and staff from the eight sites the team visited in person: the Louis Stokes facility in Cleveland, Ohio; the Togus facility in Augusta, Maine; the Fayetteville Coastal facility in Fayetteville, North Carolina; the Alvin C. York facility in Murfreesboro, Tennessee; the Royal C. Johnson facility in Sioux Falls, South Dakota; the Fort Harrison facility in Fort Harrison, Montana; the Audie L. Murphy facility in San Antonio, Texas; and the Colonel Mary Louise Rasmuson campus of Alaska facility in Anchorage.[46]

Internal Controls

The team assessed IVC's internal controls that are significant to the audit's objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[47] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following five components and eight principles as significant to the objective.[48]

The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies:

[46] The audit team selected at least one facility from each of the five regions.

[47] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[48] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

- Component: Control Environment
    - Principle 2: Exercise oversight responsibility.
    - Principle 5: Enforce accountability.
- Component: Risk Assessment
    - Principle 7: Identify, analyze, and respond to risk.
- Component: Information and Communication
    - Principle 14: Communicate internally.
- Component: Monitoring
    - Principle 16: Perform monitoring activities.
    - Principle 17: Evaluate issues and remediate deficiencies.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators by completing the Fraud Indicators and Assessment Checklist.

The OIG did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

The audit team did not use computer-processed data to support any findings, conclusions, or recommendations. IVC reported to the audit team that they implemented the Advanced Medical Cost Management Solution (AMCMS) network adequacy suite to verify the accuracy of TPA network adequacy performance reports and assess network adequacy at the facility level. However, as of December 2023, IVC had not completed its verification process of the reports and an IVC leader said IVC had not started using AMCMS to monitor network adequacy on a consistent basis. Therefore, the team decided to give IVC more time to develop AMCMS as an oversight tool before the team analyzed or evaluated the data.

Government Standards

The VA Office of Inspector General (OIG) conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: February 9, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance (VIEWS 11368028)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's draft report on oversight to evaluate network adequacy and contactor performance. The Veterans Health Administration (VHA) concurs with recommendations 1, 3, 4, 7, and 8 and concurs in principle with recommendations 2, 5, and 6. VHA provides action plans for the recommendations in the attachment.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance (OIG Project Number 2023-00876-AE-0031)

Recommendation 1. The USH ensures the Office of Integrated Veteran Care holds future third-party administrators accountable for operational readiness and provider network adequacy at each facility by the time the contracts are implemented.

VHA Comments: Concur

The Office of Integrated Veteran Care (IVC) recognizes accountability and operational readiness are key to the successful implementation of contracts. IVC firmly believes in continuous process improvement and has prioritized a full analysis of previous contract implementation, operational readiness, and identified opportunities for improvement. IVC has incorporated lessons learned from previous implementations as well as industry best practices as part of contract development for the Community Care Network Next Generation contract (CCN NG). The lessons learned are being incorporated and will enhance monitoring of performance by developing a stronger program structure and requirements for CCN NG.

As part of the pre-solicitation activities, IVC will develop a comprehensive operational plan for the CCN NG contract activities that will ensure the third-party administrators (TPAs) develop, implement, and maintain an adequate network for each VA facility. The operational plan will include key objectives and clear milestones for TPA oversight and accountability. The target completion date is reflective of pre-solicitation activities still underway for the CCN NG contract.

Status: In Progress Target Completion Date: January 2025

Recommendation 2. The USH ensures the Office of Integrated Veteran Care develops a process to make sure the third-party administrators regularly update their Community Care Network provider lists to reflect accurate provider contact information and annotate providers who are not currently accepting VA patients.

VHA Comments: Concur in Principle

Each TPA sends daily provider data updates to be incorporated into the IVC Provider Profile Management System (PPMS) as part of their contractual requirement. These updates include provider contact information as well as adding new providers and deactivating providers that are no longer in the network. This data is accessible in PPMS on the same day the TPA transmits the data. As part of ongoing efforts to improve data accuracy, the PPMS Data Team established a process in January 2024 to perform monthly data comparisons between PPMS and the respective TPA portal, looking for data inconsistencies. Any inconsistencies identified are then forwarded to the respective TPA for correction. The TPAs also have established processes to collect data discrepancies directly from field users via an e-mail or ticketing reporting system. Field users have received training and notifications of these processes, and the processes can be reviewed on the PPMS user's website.

The PPMS Data Management Team has also revised the existing PPMS Office Hours weekly training, beginning January 2024, to provide more robust training to the field on the utilization of PPMS, the steps for updating provider contact information and adding the updates to the notes field for utilization until the TPA provides the corrected information, and how to properly flag providers that have asked to be

removed from the network versus those that may temporarily not be accepting Veteran new/existing patients. This training will be ongoing for the life of the PPMS tool.

IVC is concurring in principle in response to this recommendation because, while each TPA is contractually responsible for providing daily updates of provider contact information as well as adding new providers and deactivating providers that are no longer in the network, the TPAs are not contractually required to provide updates regarding providers that may not be currently seeing Veteran patients because in the industry this is considered a temporary status. The field staff can update provider availability in PPMS by notating a provider as "Asked to be removed from the network" or "Not accepting Veterans." This action will allow other users to see this status. There is no contractual requirement for the TPAs to validate or update their information based on this availability status flag, although this information is provided to the TPAs for their internal review. The PPMS Data Management team will continue to provide training to this effect to the field users.

Status: In Progress Target Completion Date: April 2024

Recommendation 3. The USH ensures the Office of Integrated Veteran Care develops a mechanism for facilities to effectively report, track, and monitor challenges with access to specialty care services; trains all relevant staff on how to use the mechanism; make sure facilities use the mechanism routinely; and then helps facilities resolve access challenges.

VHA Comments: Concur

IVC believes strongly in ensuring the facilities can access the network needed to support Veterans receiving care in the community, and that access is dependent upon the facilities being able to report, track, and trend challenges with the network. IVC developed a ticketing system for facility staff to document recurring CCN network access issues; Network Adequacy (NA) Ticket reporting is utilized after network concerns have been brought up to the TPAs during monthly NA meetings and resolution has not been achieved. The ticketing system can be utilized by facility community care departments to escalate network concerns with the community care network. IVC's NA team reviews submissions and follows up with the facility and TPAs until resolution is achieved. IVC has an internal standard to ensure the initial assignment of submissions within 48 hours of receipt.

As part of the Soonest and Best Care initiative, field training on the Advance Medical Cost Management System (AMCMS) Network Management (NM) Suite has been provided for each station. Training was initiated in August 2023 and concluded in November 2023. This training empowers facility staff to report issues, track and monitor network performance, and build data-based justifications for network needs. The AMCMS NM suite allows users to perform several types of analysis to support network monitoring. These reports include VA Wait Time and Drive Time thresholds as well as insight into the specific claims that cause fluctuation in those times. The suite also allows users to filter for locality, specialty, category of care, standardized episode of care (SEOC), and urgency of the referred care to measure the approximate wait time from referral creation date to the first date of service or provider allocation date to the first date of service. Users can view appointment demand versus appointment availability in each locality.

Additionally, IVC is developing AMCMS NM suite sustainment training to support and reinforce the utilization of tools. NA's Regional Analysts are working directly with facility staff to address barriers. Training is slated for completion in March 2024, and NA will continue to work collaboratively with the field to ensure the tool is meeting their needs. User Acceptance Testing will be tracked to confirm successful completion and understanding of the NM suite functionality in AMCMS.

Status: In Progress Target Completion Date: April 2024

Recommendation 4. The USH ensures the Office of Integrated Veteran Care develops and communicates to facilities a standard process to request and document their needs for additional providers.

VHA Comments: Concur

IVC is committed to ensuring there are pathways of communication for all stakeholders engaged in supporting the CCN network. The monthly NA meetings were originally entered into the contract as the designated mechanism for facilities to report network concerns, however there were no standard reporting mechanisms within this forum. To better support the facilities, IVC NA developed a ticketing system in November 2023 for facility staff to document recurring CCN access issues and to escalate concerns with the community care network. The ticketing system reporting is utilized after network concerns have been brought up to the TPAs during monthly NA meetings and resolution has not been achieved. IVC's NA team reviews submissions and follows up with the facility and the TPAs until resolution is achieved. Education on the ticketing system was completed within Soonest and Best Care initiative training in November 2023 and is being encouraged by the NA team with facilities to use for escalating network issues.

In addition, each CCN contractual region is assigned a dedicated network analyst to work closely with the facilities to address network gaps and barriers with the TPA. The regional analysts are in attendance on the NA Monthly calls and serve as a liaison between the station and the TPA to escalate ongoing concerns.

A standard process to request and document needs for additional providers has been developed and communicated to VHA facilities. VHA considers this recommendation fully implemented and asks OIG to close the recommendation.

Status: Complete Completion Date: November 2023

Recommendation 5. The USH ensures the Office of Integrated Veteran Care evaluates the effectiveness of the third-party administrators' quarterly and monthly reports for assessing network adequacy and then, if needed, modifies the language in its current contracts and makes changes to the applicable contract language for future Community Care Network contracts.

VHA Comments: Concur in Principle

The intent of the TPA's quarterly and monthly reports is to evaluate NA to ensure the TPAs are proactively monitoring their network. As a result of this monitoring, VA expects the TPA to engage in provider recruitment actions when a need is identified in order to prevent the facilities from experiencing provider gaps in the network. Beginning in June 2023, IVC started validating these contractual deliverables against the AMCMS reports generated to ensure NA calculations are being accurately applied to the network. This effort occurred after IVC staff worked closely with the TPAs to align contractual understanding of the NA calculations between performance evaluation systems.

IVC is now able to validate deliverables before accepting a TPA's reported performance. This validation process is used as justification for provider recruitment in areas identified by VA as being inadequate.

IVC concurs in principle in response to this recommendation because a contract modification now is not feasible. A contract modification to change the reporting of NA deliverables would not provide benefit to the VA before the end of the current contract. IVC has documented the barriers and issues created by not having alignment of contractual calculations prior to contract implementation and is leveraging these as lessons learned for future CCN NG contracts. Requirements have been explored as part of the pre-solicitation activities for the CCN NG contract to address these lessons learned and provide for more

stringent requirements regarding TPA accountability for reporting actions taken to address network gaps. IVC is developing a comprehensive operational plan to address VA's roles and responsibilities for network implementation to ensure proper preparation and facility readiness for network reporting and oversight. The target completion date has been set to allow for the solicitation award for the CCN NG contract.

Status: In Progress Target Completion Date: January 2025

Recommendation 6. The USH ensures the Office of Integrated Veteran Care develops its own network adequacy performance reports for each facility and communicates the results to the facilities monthly.

VHA Comments: Concur in principle

To ensure VA has adequate oversight of the NA performance metrics for CCN, in March 2021, IVC developed and successfully implemented the utilization of the AMCMS NM Suite. Multiple system improvements have occurred to the system, with the most recent updates for AMCMS NM 4.0 being completed in December 2023. As part of the Soonest and Best Care initiative, NA has completed training of AMCMS NM Suite for staff at every VA facility. The training was tailored to assist facility staff in reporting and monitoring network performance. AMCMS NM suite allows users to perform several types of analysis related to the VA Wait Time and Drive Time thresholds, as well as insight into the specific claims that cause fluctuation in those times. The suite also allows users to filter for locality, specialty, category of care, SEOC, and urgency of the referred care to measure the approximate wait time from referral create date to the first date of service or provider allocation date to the first date of service. Users can view appointment demand versus appointment availability in each locality.

The training conducted for the facilities elaborated that these reports were designed to allow the facilities to monitor NA equally to how the contract describes performance and how the NA team monitors the TPAs' performance of NA. The training encouraged facilities to utilize these quantitative metrics within their monthly NA meetings with the TPAs as well as for measurement to escalate issues to the NA ticketing system for NA team support. These reports were leveraged heavily within the Soonest and Best Care initiative to improve collaboration between the facilities, TPAs, and IVC in monitoring and assessing NA and ensuring continuous collaboration across stakeholders so facilities have adequate access to the network.

IVC concurs in principle in response to this recommendation because of the prescribed requirement for monthly communication. The AMCMS reports are updated monthly and can be accessed as frequently as desired by facility staff that have been granted access to AMCMS NM, but IVC is not formally communicating the information monthly.

IVC developed NA performance reports for each facility. VHA considers this recommendation fully implemented and asks OIG to close the recommendation.

Status: Complete Completion Date: November 2023

Recommendation 7. The USH ensures the Office of Integrated Veteran Care conducts Advanced Medical Cost Management Solution training for community care staff at each facility on evaluating network adequacy through the tool.

VHA Comments: Concur

In November 2023, NA, as part of the Soonest and Best Care initiative, completed training on the AMCMS NM Suite at each station to assist facility staff in reporting and monitoring network performance.

The AMCMS NM suite allows users to perform several types of analysis on community care that has been provided, as well as viewing appointment demand versus appointment availability in each locality.

IVC has conducted Advanced Medical Cost Management Solution training for community care staff at each facility on evaluating NA through the tool. VHA considers this recommendation fully implemented and asks OIG to close the recommendation.

Status: Complete Completion Date: November 2023

Recommendation 8. The USH ensures the Office of Integrated Veteran Care routinely evaluates the third-party administrator's network adequacy performance reports to ensure the reports are sufficiently reliable and comply with contract.

VHA Comments: Concur

The third-party administrators' quarterly and monthly reports for assessing NA are a critical element for IVC to be able to assess the TPAs' calculation of NA. The intent of these deliverables is to ensure the TPAs are proactively monitoring their network, so provider recruitment actions are taken when a need is identified to prevent the facilities from experiencing gaps in the network. In June 2023, IVC initiated validation of the contractual deliverables against the AMCMS reports generated to ensure calculations were being accurately applied to the network. This effort occurred after IVC staff worked closely with the TPAs to align contractual understanding of the NA calculations between performance evaluation systems. Performance calculation alignment for all regions is estimated for June 2024.

Status: In Progress Target Completion Date: June 2024

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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